CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/16/2011 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	(X2) MI A. BUII B. WIN	LDING	NG 00 COM 10/25.		survey eted 011
	PROVIDER OR SUPPLIER			101 W 8	DDRESS, CITY, STATE, ZIP CODE 37TH AVE LVILLE, IN46410		
			-	l	LVILLE, IIVTOT IO		710
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0000							
	Complaint IN000 resulted in a part Immediate Jeopa Complaint numb substantiated, Fe related to the alle 282, F 329, F 38: Survey date: Oc	er IN00098705 deral/State deficiencies egations are cited at F 5 and F 505. tober 24, 2011 date: October 25, 2011 : 010739 r: 155764 N/A RN, TC N (10/25/11) N (10/25/11) e:	FO	000	The submission of this Plan Correction does not indicate admission by Spring Mill Hea Campus that the findings an allegations contained herin a accurate and true represents of the quality of care and ser provided to the residents of Spring Mill Health Campus. facility recognized it's obligat provide legally and medically necessary care and services residents in an economic an efficient manner. The facility hereby maintains it is in substantial compliance with requirements of participation comprehensive health care facilities (for Title 18/19 programs). To this end, this pof correction shall serve as to credible allegation of complia with all state and federal requirements governing the management of this facility. It thus submitted as a matter of statue only.	an alth d are ations vices This ion to t t to its d the for	
LADOBATOL	AV DIDECTORIC OF PROV	JIDED/CLIDDLIED DEDDECENTATIVE'S CL	CNIATION	-	TITI E		(V6) DATE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TOHB11

Facility ID:

010739

If continuation sheet

AND PLAN OF CORRECTION IDENTI		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155764	B. WING		10/25/2011
	ROVIDER OR SUPPLIER MILL HEALTH CAM		101 W	ADDRESS, CITY, STATE, ZIP CODE 87TH AVE ILLVILLE, IN46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0282	cited in accordan Quality review comp Cathy Emswiller RN The services provi	es reflect state findings ce with 410 IAC 16.2. pleted 10/30/11			
SS=D	in accordance with plan of care. Based on record facility failed to related to a Lasix (pro-time) and IN normalized ratio) clotting test) labed 4 residents review in a sample of 4. #E) Findings include 1. Resident #B's 10/24/11 at 2:15	oratory blood oratory (lab) tests for 3 of wed for physician's orders (Residents #B, #D, and	F0282	1. Resident #B no longer res at facility. Residents #D and had pertinent labs drawn per orders during the time of the survey. No negative outcome noted.2. Current residents with orders have the potential of the affected by this alleged deficiency. Physician orders current residents were review by Director of Health Service (DHS) or designee to ensure proper procedure for followin physician's orders were carriout. No adverse side effects noted.3. The deficiency was evaluated relative to system, education and compliance.	#E • MD es th lab peing for wed es eg ed were

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Event ID:

TOHB11 Facility ID:

010739

If continuation sheet

Page 2 of 28

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL		
		155764	B. WIN			10/25/2	011	
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP CODE			
SPRING	MILL HEALTH CAI	MPUS			37TH AVE LLVILLE, IN46410			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	e:111	DATE	
		ombosis (blood clot) and			In-servicing for licensed staf be conducted by DHS or de			
	hypertension.					n facility guidelines of following		
					physician's orders.4. The DI	HS or		
	A) Resident #B's physician's telephone				designee will audit physiciar	ignee will audit physician's		
	*	12/11 at 2:40 p.m., which			orders 7 days per week usin Tracking Log (see Attachme			
	was two days after the facility had been				for 2 months, then audit 4 tir			
	notified of the PT/INR results, indicated,				per week for 2 months, then	3		
	` '	adin x (times) 2 day (sic)			times per week for 2 months			
	' '	Coumadin @ (at) 2 mg			Results from the audits will to reviewed by the DHS or des			
	daily (3) Draw F	1/INR on Mon			and forwarded to the Quality			
	10/17/11".				Assurance Committee for 6			
	TI MAD 14	1.10/11 : 1: . 1.1			months or until 100% compliance			
	· ·	1 10/11, indicated the			is achieved.			
		eduled to get a PT/INR						
		here were no initials on						
		cate the PT/INR on						
	10/17/11 had be	en completed.						
	The resident's re	cord lacked						
	documentation t	o indicate a PT/INR had						
	been completed	on 10/17/11.						
	During an interv	riew on 10/24/11 at 3:05						
	p.m., the Corpor	ate RN Consultant						
		company had not drawn						
	the PT/INR on 1	0/17/11.						
	During an interv	riew on 10/24/11 at 4:15						
	_	Director of Health						
	Services) indicated a lab requisition had							
	not been filled out for the PT/INR on							
	10/17/11.							
	B) Resident #B'	s undated, physician's						

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE	
NAME OF PROVIDER OR SUPPLIER	
SPRING MILL HEALTH CAMPUS MERRILLVILLE, IN46410	
PROVIDER'S PLAN OF CORRECTION	X5)
CROSS-REFERENCED TO THE APPROPRIATE	LETION .TE
order indicated an order for Lasix	.IE
(diuretic) 40 mg (milligrams) daily at 6	
a.m.	
a.m.	
The resident's Medication Administration	
Record (MAR), dated 10/11, indicated	
Lasix 40 mg daily, written on 10/13/11.	
The MAR indicated the Lasix was started	
on 10/14/11. The MAR indicated the	
medication was scheduled at 6 a.m The 6	
a.m. had a line through it and written	
below it was, "upon rising". The MAR	
indicated the resident received the Lasix	
40 mg at 9 a.m. on 10/15/11, 9:40 a.m. on	
10/16/11, 8 a.m. on 10/17/11, 11 a.m. on	
10/18/11, and there was not time	
documented for 10/19/11 and 10/20/11.	
During an interview on 10/24/11 at 3:05	
p.m., the Corporate RN Nurse Consultant	
indicated the Lasix had not been given as	
ordered by the physician.	
2. Resident #D's record was reviewed on	
10/24/11 at 11:50 a.m. The resident's	
diagnoses included, but were not limited	
to, multiple pulmonary emboli (blood	
clots) and coronary artery disease.	
A physician's telephone order, dated	
10/05/11 at 2 p.m., indicated to	
discontinue the previous order for	
Coumadin and to start Coumadin 2.5 mg	
for two days then Coumadin 5 mg for one	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155764	B. WIN	G		10/25/2	011
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			101 W 8	87TH AVE		
	MILL HEALTH CAN	MPUS		l	LLVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE		DATE
	_	e the doses, and to repeat					
	the PT/INR in IO	0 days on 10/15/11.					
	There was a lack of documentation to						
	indicate the PT/INR had been completed						
	_						
	on 10/15/11 as ordered by the physician.						
	During an interview on 10/24/11 at 12:15						
	_						
	p.m., RN #1 indicated the PT/INR had not been completed because 10/15/11 was a						
	•						
	week-end (Saturday). She indicated there						
	was no physician's order to change the date of the PT/INR.						
	date of the P1/11	NK.					
	During an interv	iew on 10/24/11 at 1:10					
	_	icated the lab company					
		he week-end but they are					
		•					
		T (immediately) and the					
		them. She indicated the					
		lled the lab to tell them					
	tne P1/INK was	ordered for 10/15/11.					
	3 Resident #Ela	s record was reviewed on					
		0 p.m. The resident's					
		•					
	_	led, but were not limited					
	_	eart failure and coronary					
	artery disease.						
	A physician's tol	ephone order, dated					
		ed an order for a PT/INR					
	every week start	ing 10/1//11.					
	A physician's	dar datad 10/20/11					
		der, dated 10/20/11,					
	indicated to hold	I the Coumadin for two					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764		(X2) MULTIPLE CO A. BUILDING B. WING	00	r í	ESURVEY LETED 2011
NAME OF PROVIDER OR SUPPLIED SPRING MILL HEALTH CAI		STREET A	ADDRESS, CITY, STATE, ZIP COE 87TH AVE LLVILLE, IN46410	DE	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
days and to repe Saturday 10/22/	at the PT/INR on 11.				
	of documentation to NR had been completed				
p.m., the DoN ir	iew on 10/24/11 at 12:45 adicated the PT/INR had ted on 10/22/11 as				
p.m., RN #1 ind called the lab co	iew on 10/24/11 at 1:10 icated the nurse had not mpany to tell them the n ordered for 10/22/11.				
This federal tag IN00098705.	relates to complaint				
3.1-35(g)(1)					

010739

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	(X2) MULTIP A. BUILDING		oo 00	(X3) DATE S COMPL 10/25/20	ETED
		100704	B. WING	2222		10/20/20	311
NAME OF P	ROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP CODE TH AVE		
SPRING	MILL HEALTH CAN	1PUS			VILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	IAC	G	DEFICIENCE)		DATE
F0329 SS=J	from unnecessary drug is any drug we (including duplicate duration; or without without adequate is the presence of accindicate the dose sediscontinued; or an reasons above. Based on a compresident, the facility residents who have drugs are not given antipsychotic drugs treat a specific condocumented in the residents who use gradual dose reduinterventions, unlein an effort to discondict discondictive facility failed to resulted in a resident of the control of the facility failed to resulted in a resident of the facility also for physicians timely	els as ordered, which dent receiving Vitamin K coagulation) due to a C/INR (Resident #B) and failed to notify resident's of high PT/INR's, which	F0329		1) Resident #B no longer residents at facility, however, the physion was notified of the PT/INR resonant addressed the issue with further negative outcomes. Residents #D, #E #F had pertinent labs drawn at the time of survey. The residence evaluated and no negation outcomes were noted.2) Curricesidents receiving Coumadir have the potential of being affected by this alleged	cian sults no and at ents ive rent	11/16/2011
	Coumadin orders	es in the resident's This affected 3 of 4 every decived Coumadin in a			deficiency. Current residents receiving Coumadin and requiring PT/INR's were identified. Lab		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE COMPL	
		155764	A. BUI B. WIN	LDING IG		10/25/2	011
NAMEOF	DDOMNED OD GUDDU TED	,			ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER				B7TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRIL	LVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAU	 	sidents #B, #D, and #E)		IAU	results were reviewed and		DATE
	• ,	e residents in immediate			physicians were notified of re	sults	
		ility failed to monitor a			accordingly.3) The deficiency	/ was	
		1 of 2 residents receiving			evaluated relative to system, education and compliance. T	'nο	
		upplemental sample of 2.			facility practice for reporting l		
	(Resident #F)	11			results to the physician was		
					reviewed and nursing staff w in-serviced by the DHS or	as	
	The immediate jo	eopardy began on			designee on the policy addre	ssing	
		he facility failed to notify			reporting lab results. The lab tracking log and individual		
	a resident's phys	ician in a timely manner					
	of a high PT/INF	R, which the physician			Coumadin records were implemented with nursing sta	aff	
	held the Coumac	lin for two days, failed to	in-serviced on completion of the				
		resident's physicians			forms. 4) The DHS or designee	ee	
		Γ/INR's and failed to			will audit current residents requiring the use of Coumad	in 7	
	_	ent from undue adverse			days per week for 2 months,		
		equences by not obtaining			4 times per week for 2 month		
		ered by the physician. The			then 3 times per week for 2 months.[See Attachment B,		
		tor, Director of Nursing,			Resident Coumadin/Coag Te	esting	
	_	onsultant, and the			Record]. Results from the au	dits	
		President were notified of			will be reviewed by the DHS		
		opardy at 5:45 p.m. on			designee and forwarded to the Quality Assurance Committee		
		nmediate jeopardy was 25/11 at 3:50 p.m., but			months or until 100% compli		
		remained at the lower			is achieved.		
		ty level of isolated, no					
	_	potential for more than					
		at is not immediate					
	jeopardy.						
	J - F J -						
	Findings include	:					
	1. Resident #B's	record was reviewed on					
	10/24/11 at 2:15	p.m. The resident's					
	diagnoses includ	ed, but were not limited					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MUL	TIPLE CO	NSTRUCTION		(X3) DATE COMPL	
AND PLAN	OF CORRECTION	155764		A. BUILD	ING	00		10/25/2	
		133704		B. WING				10/23/2	011
NAME OF I	PROVIDER OR SUPPLIER					ADDRESS, CITY, STA	ATE, ZIP CODE		
ODDING	NAUL LIEALTILOAS	ADUI0				B7TH AVE	40		
SPRING	MILL HEALTH CAN	//PUS			MERRIL	LVILLE, IN464	10		
(X4) ID		TATEMENT OF DEFICIENCIE			ID		PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY			REFIX	CROSS-REFERENC	VE ACTION SHOULD BE ED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORM			TAG	DEF	FICIENCY)		DATE
		ombosis (blood clot) a	and						
	hypertension.								
	The resident was admitted into the facility on 10/08/11 from the hospital. An admission order, dated 10/08/11 indicated								
	· ·								
		madin 2.5 mg daily at	ııu						
	to check the resident's INR weekly.								
	A PT/INR result, dated 10/10/11,								
	indicated the resident's PT was high at								
	36.6 (normal 10-12) and the INR was high at 4 (normal 2-3). The results indicated								
	` ′	xed to the facility on	tu						
	1	a.m. Written on the							
		/INR results indicated	1						
		s notified of the resul							
		te was documented.	ne						
	_	l, "Hold Coumadin							
	` ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′	then resume @ (at) 2	mg,						
	PT/INR on Mon.	. 10/1//11."							
	A nurgos! note d	ated 10/12/11 at 2:40							
	p.m., indicated, "								
	p.m., indicated, " (physician's name	• '							
	<i>a</i> 3	**							
		ec'v (received) new							
	orders"								
	A physician's tal	ephone order, dated							
		p.m., which was two							
		-	d of						
	days after the facility had been notified of the PT/INR results, indicated, "(1) Hold Coumadin x2 day (sic) (2) then resume								
	·	• • • • •	е						
		ng daily (3) Draw							
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Ev	ent ID: TC)HB11	Facility I	D: 010739	If continuation sh	eet Pa	ge 9 of 28

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764			LDING	ONSTRUCTION 00	(X3) DATE COMPL 10/25/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	.	•		ADDRESS, CITY, STATE, ZIP CODE	•	
SPRING	MILL HEALTH CAN	MPUS			37TH AVE LLVILLE, IN46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	PT/INR on Mon	<u> </u>		IAG	,		DAIL
	The resident's M Administration I indicated the res Coumadin on 10 supper and the C 10/12/11 and 10. The MAR, dated resident received supper on 10/14, and 10/17/11. The MAR, dated resident was sch on 10/17/11. The MAR to indi 10/17/11 had bed. The resident's redocumentation to been completed A PT/INR result indicated a high 10-12) and a crit 2-3). A physician's tel 10/18/11 at 8:30 vitamin K 10 mg	AR (Medication Record), dated 10/11, ident received 2.5 mg of 0/10/11 and 10/11/11 at Coumadin was held on /13/11. I 10/11, indicated the I Coumadin 2 mg daily at /11, 10/15/11, 10/16/11, indicated the eduled to get a PT/INR here were no initials on cate the PT/INR on en completed.					
	Hold Coumadin	today"					

	OT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		NSTRUCTION 00	(X3) DATE S COMPLI	ETED
		155764	B. WING			10/25/20	J11
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE 7TH AVE		
SPRING	MILL HEALTH CAN	1PUS			LVILLE, IN46410		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	F	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	ROSS-REFERENCED TO THE APPROPRIATE	
	The PT/INR result indicated a PT at During an intervipular, the Corporation indicated the label the PT/INR on 10 During an intervipular, the DHS (E. Services) indicated the label the PT/INR on 10 During an intervipular, the DHS (E. Services) indicated to 10/17/11. During an intervipular, the DHS in not been aware the completed on 10/3:05 p.m. A facility policy, received from the "Lab Tracking G facilitate a method tests ordered and completed in a tire."	alts, dated 10/19/11, 31.7 and INR at 3.4. sew on 10/24/11 at 3:05 ate RN Consultant company had not drawn	F		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION DATE
		or or Director of Health					
		onitor the "Tracking Log"					
		ve been completed per					
	the physician's or	rder. 3. When results are					
		be so noted on the					
	"Tracking Log" v	with the physician					

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155764	B. WIN	G		10/25/2	011
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	ROVIDER OR SOLI LIEF				B7TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRIL	LLVILLE, IN46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	notified of the re	sults"					
		record was reviewed on					
	10/24/11 at 11:50 a.m. The resident's						
	diagnoses includ	ed, but were not limited					
	to, multiple pulmonary emboli (blood						
	clots) and coronary artery disease.						
		sult, dated 10/04/11, and					
	faxed to the facility on 10/04/11 at 7:17						
	a.m., indicated the resident's physician						
	was notified of the high PT result of 28.7						
	and INR of 3.1,	on 10/05/11 at 2 p.m.,					
	which was over	24 hours after the results					
	had been faxed t	o the facility.					
	A physician's ord	der, dated 09/27/11 at 8					
	p.m., indicated tl	ne resident had received					
	Coumadin 5 mg	alternating every day					
	with Coumadin 2	2.5 mg.					
	A physician's tel	ephone order, dated					
	10/05/11 at 2 p.n	n., indicated to					
	discontinue the p	previous order for					
	_	start Coumadin 2.5 mg					
		n Coumadin 5 mg for one					
	_	e the doses, and to repeat					
	l -) days on 10/15/11.					
		-					
	There was a lack	of documentation to					
	indicate the PT/I	NR had been completed					
		rdered by the physician.					
		- * *					
	A PT/INR result	, dated 10/18/11,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155764	B. WIN	G		10/25/20	011
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
CDDING	MILL HEALTH CAN	ADUC			37TH AVE LLVILLE, IN46410		
					LVILLE, IN404 IU		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO			(X5)
PREFIX TAG	,	ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		f 20.4 and an INR of 2.1.		mo	<u> </u>		DATE
		he bottom of the result					
	_	o continue the same dose					
		to repeat the PT/INR in					
	two weeks.	to repeat the 1 1/11vix in					
	WO WEEKS.						
	During an interv	riew on 10/24/11 at 12:15					
	_	icated the PT/INR had not					
		because 10/15/11 was a					
		day). She indicated there					
	,	n's order to change the					
	date of the PT/IN	_					
	During an interv	riew on 10/24/11 at 1:10					
	_	icated the lab company					
		he week-end but they are					
		T (immediately) and the					
		them. She indicated the					
		lled the lab to tell them					
	the PT/INR was	ordered for 10/15/11.					
	3. Resident #E's	s record was reviewed on					
	10/24/11 at 12:3	0 p.m. The resident's					
	diagnoses includ	led, but were not limited					
	to, congestive he	eart failure and coronary					
	artery disease.						
	A physician's tel	ephone order, dated					
	10/12/11 indicat	ed an order for a PT/INR					
	every week start	ing 10/17/11.					
	A PT/INR result	, dated 10/17/11,					
		ults were faxed to the					
	facility on 10/17	/11 at 8:15 a.m. The					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764			LDING	NSTRUCTION 00	(X3) DATE : COMPL 10/25/2	ETED	
NAMEOU	DDOMNED OF CIRPLIES	<u> </u>	D. WIIV		DDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER				B7TH AVE		
	MILL HEALTH CAN			l	LLVILLE, IN46410		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
	PT/INR results in	ndicated the facility had					
	attempted to notify the resident's						
	1 2	17/11 at 1:15 p.m., 2:30					
	-	and 10:15 p.m. of the					
	_	Γ at 33 and INR at 3.6.					
	responded to the	red the physician had not					
	responded to the	pages.					
	The PT/INR resu	alts indicated the					
	physician had be	en made aware of the					
	PT/INR results of	on 10/18/11 at 8 a.m. (24					
	· ·	physician had wrote on					
	the PT/INR resul	Its to see order.					
	A signed physici	an's order, dated 10/19/11					
		icated to hold the					
		/11 and then to start					
	Coumadin 1 mg	daily.					
		AR, dated 10/11,					
		ident had an order for					
	_	take 1/2 tablet daily (1 d the resident had					
		imadin 1 mg on 10/17/11					
	and 10/18/11.	middii 1 iiig 0ii 10/1//11					
	A physician's ord	der, dated 10/20/11,					
		the Coumadin for two					
	1 -	at the PT/INR on					
	Saturday 10/22/1	11.					
	There was a lack	of documentation to					
		NR had been completed					
	on 10/22/11.	rr					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764			A. BUI	LDING	00	COMPL	
		155764	B. WIN	G		10/25/20	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ODDINO		40110			B7TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRIL	LLVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Daning on inton-	i 10/24/11 -+ 12:45					
	_	iew on 10/24/11 at 12:45					
	1 *	dicated the PT/INR had					
	ordered.	ted on 10/22/11 as					
	ordered.						
	During on interes	iew on 10/24/11 at 1:10					
		cated the nurse had not					
	1	mpany to tell them the					
		n ordered for 10/22/11.					
	F 1/11NK Had beel	11 OTUCTEU 101 10/22/11.					
	The facility police	cy titled "Physician					
		delines" was received as					
		Executive Director on					
		p.m.,indicated "To					
		nt's physician is aware of					
		ting results or change of					
		nely manner to evaluate					
		ed of provision of					
		ventions for care12. If					
		ysician does not respond					
		tempts after three phone					
		Director and Director of					
		should be notified for					
	further instruction						
		r Resident #F was					
		25/11 at 9:10 a.m. The					
		ses included, but were					
		rial fibrillation, coronary					
		nd peripheral vascular					
		dent was admitted to the					
	facility on 10/7/1						
		.1,					
	A Physician's Or	der dated 10/7/11,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION		X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUM	MBER:	A. BUIL	DING	00		COMPL	ETED
		155764		B. WING				10/25/2	011
NAME OF T	DOMDER OF GURNING	<u> </u>				ADDRESS, CITY, STA	ATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	K			101 W 8	B7TH AVE			
	MILL HEALTH CAI					LVILLE, IN464	10		
(X4) ID		STATEMENT OF DEFICIE			ID		PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PERCEDE			PREFIX	CROSS-REFERENCE	/E ACTION SHOULD BE ED TO THE APPROPRIAT TICIENCY)	E	COMPLETION
TAG		R LSC IDENTIFYING INF		-	TAG	DEF	ICIENCI)		DATE
		ident was to receive							
	· ·	ood thinner) 5 mill	_						
		daily. The residen							
	<u> </u>	tory orders for a P	T/INR						
	at the time of ad	mission.							
		dated 10/18/11, in							
	the resident was	at risk for bleedin	g						
		pagulant use and a	•						
	use. The interv	entions indicated t	to						
	provide the anti-	coagulant medica	tion as						
	prescribed by the	e physician, and re	eport lab						
	results to physic	ian and follow phy	ysician						
	recommendation	ns for abnormal lab	os.						
	A Physician's O	rder dated 10/24/1	1.						
	1	ident was to have							
		sults were dated 1							
		facility at 7:45 p.r							
		ne (PT) was high a							
		econds. The reside							
		critical at 6.8. The	ant o						
			and						
		otified at 7:50 p.m	., and						
	orders were rece		. 41						
		vo days and repeat							
		7/11. On 10/27/11	-						
		adin was to be dec	reased						
	from 5 mg to 3 r	ng daily.							
	The UD 11 + C	No. T. W. D.	10						
		Coag Testing Reco							
	located in the Medication Administration								
	Record (MAR), indicated the only								
	PT/INR listed as being completed was on								
	10/24/11.								
FORM CMS-2	.567(02-99) Previous Versi	ions Obsolete	Event ID:	TOHB11	Facility l	ID: 010739	If continuation sh	eet Pa	ge 16 of 28

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764		(X2) MU A. BUII		NSTRUCTION 00		OATE SURVEY COMPLETED 0/25/2011	
		100/04	B. WIN				0/25/2011
	PROVIDER OR SUPPLIER			101 W 8	ADDRESS, CITY, STATE, ZIP 87TH AVE	CODE	
SPRING	MILL HEALTH CAN	IPUS		MERRIL	LVILLE, IN46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE APPROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	10:18 a.m., indice was admitted on notify the physic orders. She furth on Coumadin used drawn weekly. Interview with the 10:55 a.m., indice have a physician admission. She is drawn on 10/24/1 had been drawn suffurther indicated draw was determent that PT/INR's weekly.	PN #1 on 10/25/11 at ated that when a resident Coumadin, she would ian and ask for PT/INR her indicated the residents hally have a PT/INR The DHS on 10/25/11 at ated the resident did not ated the resident did not ated the PT/INR The PT/INR at an indicated the PT/INR The PT/INR at a indicated the PT/INR The properties of the Indicated In					
	week or once ever residents receiving	ery two weeks for ng Coumadin.					
	10/10/11 was renthe facility had a records who recepT/INR's and oth deficiencies were obtained orders f who did not have monitor. Quality initiated to monito to ensure they are timely physician	eopardy that began on noved on 10/25/11 when udited the residents' eived Coumadin for ner laboratory testing, and ecorrected. The facility for PT/INR's for residents exphysician's order to Assurance audits were tor PT/INR and other labs ecompleted as ordered, notification, and changes s. 28 of 35 nurses had					

010739

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764			LDING	NSTRUCTION 00	(X3) DATE COMPL 10/25/2	ETED	
NAME OF F	ROVIDER OR SUPPLIER	<u> </u>	-	STREET A	DDRESS, CITY, STATE, ZIP CODE		
	MILL HEALTH CAN				37TH AVE LVILLE, IN46410		
				<u> </u>			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
	been inserviced a	and the nurses who had					
	not been inserviced are scheduled to be inserviced prior to reporting for duty.						
		e interviewed and they					
		e the facility protocol for					
		ician notification, and					
	_	tests. The DHS or her					
	_	dit all physician orders even days a week,					
	•	adin tracking logs for					
	deficiencies and						
	re-inserviced on						
		ess and correct any					
		ey are found. Audits will					
		ven days a week for two					
	months, then fou	r times a week for two					
	months, then thre	ee times a week for two					
	months. The DH	S will report findings to					
		rance Committee					
	monthly for six r	nonths.					
		1					
	_	relates to complaint					
	IN00098705.						
	3.1-48(a)(3)						
	3.1 40(u)(3)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764			(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE (COMPL 10/25/20	ETED
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
SPRING	MILL HEALTH CAN	1PUS			LVILLE, IN46410		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
F0385 SS=D	a recommendation admitted to a facility remain under the of the facility must e of each resident is and another physicare of residents with physician is unavariated. Based on record facility failed to opprovided medical the resident's physician to the facility state (pro-time) and IN normalized ratio clotting test) lever reviewed for physician test) lever reviewed for physician medical care in a (Resident #E) Findings include Resident #E's reconstruction and the resident #E's reconstruction and the facility state (pro-time) and IN normalized ratio (pro-time) and IN no	review and interview, the ensure a physician I care to a resident when visician had not responded ff to treat a high PT NR (international of (laboratory blood els for 1 of 4 resident's resician responding for total sample of 4.	F0	385	1. Resident #E's chart was reviewed and physician was notified during time of the sur No negative outcomes noted Current residents have the potential to be effected by the alleged deficiency. Current residents were reviewed for supervision of physician services.3. The deficiency we evaluated relative to system, education and compliance. Licensed staff will be in-servi by DHS or designee on Phys Notification Guidelines.4. The DHS or designee will audit al residents requiring necessary services 7 days per week for months, then 4 days per week 2 months, then 3 days per we for 2 months. [See Attachme and B]. Results from the aud will be reviewed by the DHS	e as as acced sician e ll y lab 2 ek for eek nts A its	11/16/2011

NAMI OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS (VA) ID SIMMARY STATEMENT OF DEPICITIVETS (EACH DEPICES TYME) IN STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, ING6410 (VA) ID SIMMARY STATEMENT OF DEPICITIVETS (EACH DEPICES TYME) IN SIMMARY STATEMENT OF DEPICITIVETS (EACH DEPICES TYME) IN SIMMARY STATEMENT OF DEPICES TYME APPROPRIATE (EACH DEPICES TYME) IN SIMMARY STATEMENT OF DEPICITIVETS (EACH DEPICES TYME) IN SIMMARY STATEMENT OF DEPICITIVETS (EACH DEPICES TYME) IN SIMMARY STATEMENT OF DEPICITIVE STATEMENT OF DEPICITION OF THE APPROPRIATE DEPICES TO THE APPROPRIATE DEPICES OF	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764		ĺ	ULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPL	ETED	
SPRING MILL HEALTH CAMPUS (CA):ID SIAMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PERCEDED BY FILL TAGE (EACH DEFICIENCY MIST BE PERCED BY FILL TAGE (EACH DEFICIENCY MIST BE PERCEDED BY FILL TAGE (EACH DEFICIENCY MIST BE PERCED BY FILL TAGE (EACH DEFICIENCY MIST BE PERCEDED BY FILL TAGE (EACH DEFICIENCY MIST BE PERCED BY FILL TAGE (EACH DEFICE BY FILL TAGE (EACH DEFICIENCY MIST BE PERCED BY FILL TAGE (EACH DEFICIENCY MIST BE PERCED BY FILL TAGE (EACH DEFICIENCY			155764	B. WIN	G		10/25/2	011
SPRING MILL HEALTH CAMPUS MERRILLVILLE, IN46410 (X5)	NAME OF I	PROVIDER OR SUPPLIER						
SUMMARY STATEMENT OF DEPICIENCIES TAG PROFILE	SDDING	MILL HEALTH CAN	ADI IS					
REPETX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) to, congestive heart failure and coronary artery disease. A physician's telephone order, dated 10/12/11 indicated an order for a PT/INR every week starting 10/17/11. A PT/INR result, dated 10/17/11, indicated the resident's PT was high at 33 (normal 10-12) and the INR was 3.6 (normal 2-3). The PT/INR results indicated the facility had attempted to notify the resident's physician on 10/17/11 at 1:15 p.m., 2:30 p.m., 7:15 p.m., and 10:15 p.m. of the residents high PT at 33 and INR at 3.6. The form indicated the physician had not responded to the pages. The PT/INR results indicated the physician had wrote on the PT/INR results to see order. A signed physician's order, dated 10/19/11 at 2:20 p.m., indicated the hot start Coumadin 1 mg daily. During an interview on 10/24/11 at 12:45 p.m., RN #1 indicated the staff should								avs)
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at 2:20 p.m., indicated to hold the Coumadin 10/19/11 and then to start Coumadin 1 mg daily. During an interview on 10/24/11 at 12:45 p.m., RN #1 indicated the staff should		the PT/INR resul	ts to see order.					
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During an interview on 10/24/11 at 12:45 p.m., RN #1 indicated the staff should								
p.m., RN #1 indicated the staff should		Coumadin I mg	dany.					
p.m., RN #1 indicated the staff should		During an intervi	iew on 10/24/11 at 12·45					

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/25/2011
	ROVIDER OR SUPPLIER		101 W 8	ADDRESS, CITY, STATE, ZIP CODE 87TH AVE LLVILLE, IN46410	•
	PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL				
F0505 SS=E	physician of the fir Based on record	romptly notify the attending ndings. review and interview, the promptly notify residents'	F0505	The physician was notified the lab results for Resident: #E, #D and #G. No negatives.	s #B,

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL		
AND PLAN	OF CURRECTION	155764		LDING	00	10/25/2	
		100704	B. WIN		DDDDGG CVTV CT CT CO	10/23/2	011
NAME OF	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
SPRING	MILL HEALTH CAN	MPUS			LVILLE, IN46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		TE	COMPLETION
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)		TAG			DATE
	1 ^ *	Γ (pro-time) and INR			outcomes noted.2. Current residents receiving lab service	es.	
	(international normalized ratio) (laboratory blood clotting test) levels for 3				have the potential to be effect		
					by the alleged deficiency. Cu		
		viewed for timely			residents were reviewed for		
	1 ^ -	ation of laboratory (lab)			physician notification of lab		
	1	of 4 (Residents #B, #D,			results and/or change of condition. Physicians were		
	and #E) and 1 of				notified of results accordingly	/.3.	
	supplemental sar	mple of 2 (Resident #G).			The deficiency was evaluate		
					relative to system, education		
	Findings include	:			compliance. Licensed staff w in-serviced by DHS or design		
					on Physician Notification	100	
	1. Resident #B's	record was reviewed on			Guidelines.4. The DHS or		
	10/24/11 at 2:15	p.m. The resident's			designee will audit current	_	
	diagnoses includ	ed, but were not limited			residents requiring lab servic days per week for 2 months,		
	to, deep vein thre	ombosis and			4 days per week for 2 months,		
	hypertension.				then 3 days per week for 2 months. [See Attachment A].		
	The resident was	admitted into the facility			Results from the audits will b		
		n the hospital. An			reviewed by the DHS or desi		
		dated 10/08/11 indicated			and forwarded to the Quality		
	1	madin 2.5 mg daily and			Assurance Committee for 6 months or until 100% compli	ance	
		dent's INR weekly.			is achieved.		
	lo check the resi	dones have woodly.					
	A PT/INR result	, dated 10/10/11,					
	indicated the res	ident's PT was high at					
	36.6 (normal 10-	12) and the INR was high					
	at 4 (normal 2-3)). The results indicated					
	they had been fa	xed to the facility on					
	10/10/11 at 8:52	a.m. Written on the					
	bottom of the PT	/INR results indicated					
	the physician wa	s notified of the results at					
	2:40 p.m., no dat	te was documented. The					
	writing indicated	l, "Hold Coumadin					
	x(times) 2 days,	then resume @ (at) 2 mg,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764			(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 10/25/20	ETED
NAME OF P	ROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
	MILL HEALTH CAN				7TH AVE LVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	LVILLE, HVTOTIU	I	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	PT/INR on Mon.	10/17/11."					
	p.m., indicated, " (physician's nam	• '					
	10/12/11 at 2:40 days after the fact the PT/INR resul Coumadin x2 day	ephone order, dated p.m., which was two cility had been notified of lts, indicated, "(1) Hold y (sic) (2) then resume ng daily (3) Draw 10/17/11".					
	p.m., the Directo acknowledged th	iew on 10/24/11 at 5:15 r of Health Services le lab had been faxed to 1/10/11 at 8:52 a.m. No on was given.					
	10/24/11 at 11:50 diagnoses includ	record was reviewed on 0 a.m. The resident's ed, but were not limited nonary emboli and lisease.					
	faxed to the facil a.m., indicated the was notified of the and INR of 3.1, of	sult, dated 10/04/11, and ity on 10/04/11 at 7:17 he resident's physician he high PT result of 28.7 on 10/05/11 at 2 p.m., 24 hours after the results					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155764	B. WIN	G		10/25/2	011
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					87TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRII	LLVILLE, IN46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	had been faxed t	o the facility.					
		record was reviewed on					
		0 p.m. The resident's					
	_	led, but were not limited					
	to, congestive he	eart failure and coronary					
	artery disease.						
	A physician's tel	ephone order, dated					
	10/12/11 indicat	ed an order for a PT/INR					
	every week start	ing 10/17/11.					
	A PT/INR result	, dated 10/17/11,					
	indicated the res	ults were faxed to the					
	facility on 10/17	/11 at 8:15 a.m. The					
	· ·	ndicated the facility had					
	attempted to not	•					
	•	17/11 at 1:15 p.m., 2:30					
		and 10:15 p.m. of the					
	-	Γ at 33 and INR at 3.6.					
	_	ted the physician had not					
	responded to the						
	responded to the	pages.					
	The PT/INR race	ults indicated the					
		en made aware of the					
	1 3						
		on 10/18/11 at 8 a.m. (24					
	· ·	physician had wrote on					
	the PT/INR resu	its to see order.					
	A	St					
		ian's order, dated 10/19/11					
	* '	icated to hold the					
		/11 and then to start					
	Coumadin 1 mg	daily.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	A. I	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED 10/25/2011		
		150704	В. V	WING			10/23/20	011	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE					
SPRING MILL HEALTH CAMPUS					LVILLE, IN464	10			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		≣	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)			DATE	
	_	riew on 10/25/11 at 8:35							
		ate Divisional Vice							
		ted there was a delay in							
	physician notification of the lab results.								
	4. The record for Resident #G was								
	reviewed on 10/25/11 at 8:45 a.m. The								
		t admitted to the facility							
		resident was readmitted							
	_	9/1/11. The resident's							
	_	led, but were not limited							
	to, malignant neoplasm of the bronchus								
		stive heart failure, high							
	_	and malignant neoplasm							
	of the brain.								
	Review of the 9/	1/2011 Physician orders							
		ident was to receive							
	Coumadin (an m	nedication to thin the							
	,	nt blood clots) 2.5							
	_	ablet. There was also an							
	_	R (blood tests to check							
		boratory tests to be							
	completed weekly starting on 9/5/11.								
		der was written on							
	· · · · · · · · · · · · · · · · · · ·	ed to discontinue the							
		nilligrams and to start							
		nilligrams daily. A							
		r was written on 9/29/11							
		Coumadin to 5 milligrams							
	one tablet daily s	starting on 9/30/11.							
	Review of the 10	0/2011 laboratory tests							
		dicated a PT/INR							
EODM CMC 2			TO::-	144 E- 117-1	D: 040=00	If a maximum of the state of th	nat 5	05 . 100	
FURM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	TOHE	311 Facility	D: 010739	If continuation she	rei Pag	ge 25 of 28	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155764	B. WING	ING		10/25/2011		
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE			
					7TH AVE LVILLE, IN46410			
SPRING MILL HEALTH CAMPUS					LVILLE, IN40410			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE	
	laboratory test w							
	10/11/11. The P							
	PT 20.4 (normal 10-12) INR 2.1 (therapeutic range 2-3) Documentation on the results page							
	indicated the results were faxed to the facility on 10/24/11. Documentation							
	*	sults page also indicated						
		s notified on 10/24/11.						
		ntory test was completed						
		e results were as follows:						
	PT 19.6 INR 2.0							
		written on the results page						
		ults were faxed to the						
	facility on 10/18/							
	*	vritten on the results page						
	also indicated the	e physician was notified						
	on 10/24/11.							
		(2011) I D						
	Notes indicated t	0/2011 Nurses' Progress						
		f the physician being						
		0/11/2011 and 10/18/11						
		s prior to 10/24/2011.						
	1	ed Nursing Assessment &						
	Data Collection"	forms completed						
	_	10/20/11 indicated there						
		tation of the physician						
	•	the 10/11/11 and the						
	10/25/11 PT/INR	ζ.						
	When interviewe	ed on 10/25/11 at 9:10						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		ſ ´		ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 155764		LDING	00	COMPLETED 10/25/2011	
1557.04			B. WIN			10/23/2	011
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
SPRING MILL HEALTH CAMPUS			101 W 87TH AVE MERRILLVILLE, IN46410				
(X4) ID				ID	·		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	a.m., the Director of Nursing indicated the						
	Medical Director	was notified of the					
	10/18/11 results	on 10/24/11. The					
	Director of Nursi	ing indicated the Medical					
	Director was notified of the laboratory results on 10/24/11 after the facility had the results faxed over to the facility on						
	10/24/11.						
	The feetite and						
		ey titled "Physician delines" was received as					
		Executive Director on					
		p.m., indicated "To					
		nt's physician is aware of					
	_	ting results or change of					
		nely manner to evaluate					
		ed of provision of					
	^ ^	ventions for care12. If					
		ysician does not respond					
		tempts after three phone					
		Director and Director of					
	Health Services should be notified for						
		ns." The policy indicated					
		ould be notified of critical					
		immediate need by phone					
		sults are known. All					
		s or order requests may					
	_	hysician's office during					
		agnostic tests results					
		se from the physician					
	noting they have	reviewed the test results.					
	This federal tag i	relates to complaint					
	IN00098705.	<u> </u>					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TOHB11 Facility ID:

010739

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN46410 (X5) PREFIX (EACH CORRECTION HOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE COMPLETE DATE	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLET.	
SPRING MILL HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE COMPLET	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
I CROSS-REFERENCED TO THE APPROPRIATE	
3.1-49(f)(2)	